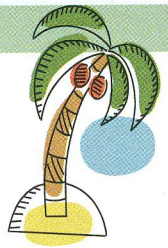
WELCOME



Turley Dental Corporation
14650 Aviation Blvd #175
Manhattan Beach, Ca 90250
(310) 643-0125

Date_____

Confidential Patient Information

Patient's Name_____ M / F (circle)

Address _____ City_____Zip Code_____How Long_____

Home Phone_____ Birthdate_____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Insurance Information

Primary Policy Holder's Name _____ and Soc. Sec. #_____

Ins. Company _____Group No._____Union Local No._____

Ins. Co. Address _____Ins. Co. Phone_____

Do you have dual coverage? ☐ No ☐ Yes If yes: E-mail:_____

Secondary Policy Holder's Name_____ and Soc. Sec. #_____

Ins. Company _____Group No._____Union Local No._____

Ins. Co. Address _____Ins. Co. Phone_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____ Update (date & initial)_____

Confidential Responsible Party Information

Name_____ Marital Status_____ M / F (circle)

Residence _____ City_____Zip Code_____How Long_____

Mailing Address _____

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Birthdate_____Relationship to Patient_____

Employer _____ Occupation_____ No. Years Employed_____

Spouse's Name _____Relationship to Patient_____

Employer _____ Occupation_____ No. Years Employed_____

Social Security # _____ Birthdate_____Work/Cell Phone_____

Dental History

Reason For Orthodontic Examination: _____

Has Patient Had Previous Orthodontic Treatment / Consultation? ☐ Yes ☐ No

Speech Problems	☐ Yes	☐ No	Thumb Sucking	☐ Yes	☐ No	Have Tonsils Been Removed	☐ Yes	☐ No
Lip Biting	☐ Yes	☐ No	Finger Biting	☐ Yes	☐ No	Food Collection Between Teeth	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Grinding Teeth	☐ Yes	☐ No	Clicking or Popping of the Jaw	☐ Yes	☐ No
Periodontal Treatment	☐ Yes	☐ No	Mouth Breather	☐ Yes	☐ No	Trauma to Teeth or Jaw	☐ Yes	☐ No

Medical History

Physician's Name: _____ Ph. #: _____

Address: _____

If patient is a child:

Has patient reached puberty? ☐ Yes ☐ No Girl - started menstruation? ☐ Yes ☐ No Boy - has voice changed? ☐ Yes ☐ No

Date of last physical exam: _____ Results: _____

Is patient under care of a physician now? Y / N If yes, why _____

Has patient ever been hospitalized? Y / N If yes, why _____

Has patient ever had surgery? Y / N If yes, why _____

HAVE YOU HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO:

Y N A.I.D.S./H.I.V.	Y N Cerebral Palsy	Y N Hay Fever	Y N Mental Retardation
Y N Anemia	Y N Cleft Lip/Palate	Y N Hearing Problems	Y N Phen Phen
Y N Asthma	Y N Convulsion	Y N Heart Problems	Y N Premature Birth
Y N Bladder Problems	Y N Developmental Disability	Y N Hepatitis	Y N Rheumatic Fever
Y N Blood Transfusion	Y N Diabetes	Y N Jaundice	Y N Sinus Problems
Y N Bruise Easily	Y N Epilepsy	Y N Kidney Disease	Y N Thyroid Disease
Y N Cancer	Y N Fainting	Y N Liver Disease	Y N Tuberculosis

Other: _____

Has patient ever had an asthmatic attack? If yes, Mild Moderate Severe And when and how often: _____

Is patient receiving any medication? Y / N If yes, list names and purpose: _____

_____

ARE YOU ALLERGIC TO, OR EVER HAD AN ADVERSE REACTION TO THE FOLLOWING? IF YES, PLEASE CIRCLE:

Aspirin Barbiturates Sedatives Metal Local Anesthetics Amoxicillin Sleeping Pills Sulfa Drugs Latex None Known Any others _____

I understand that the information that I have given is correct, that it will be held in confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature _____ ***Date*** _____